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Global mental health in a time of change

Davide Ziveri • Spécialiste de la santé planétaire au sein de l'ONG Humanité & Inclusion (Handicap International)

It is a difficult exercise in summary writing that Davide Ziveri undertakes here. Looking at the six articles in this issue, he attempts to put them into perspective in the light of global health, his specialist area, to arrive at some semblance of a forecast.

Change is profoundly relevant to the social sciences as a subject of research, a field of action and a self-reflective practice. This issue of *Humanitarian Alternatives* is a timely guide through the discourse on change in the field of mental health and psychosocial support (MHPSS).

On the threshold of a new critical juncture

Humanitarian aid sets its values and practices in accordance with the spirit of the times. This gives it meaning and the possibility to take action within a society, in a specific historical period. In an almost cyclical way, humanitarian aid actors are facing major changes, or "critical junctures".[1] This has been particularly noticeable in recent years when there has been much talk of a paradigm shift (in values, power relations, the interpretation of problems and repertoires of contention)[2] which calls for changing the discourse produced in all sectors of knowledge and professional practices.

Mental health is no exception to this movement. The advent of psychology and psychiatry in humanitarian contexts – such as the very first humanitarian mental-health mission which Laure Wolmark describes in relation to Médecins Sans Frontières (MSF) in Armenia in late 1989[3] – was a response to one of these junctures characterised by particular public sensitivity and momentum within the association. This mission was based on knowledge that opened up to the notion of trauma (and its blind spots), giving shape and meaning to an intervention system that was still in its infancy and would take time to stabilise within the MSF network, often through a variety of approaches.

[1] Clara Egger, "About the critical junctures in humanitarian history", *Humanitarian Alternatives*, no. 9, 2018, pp. 1–5.
[2] Charles Tilly, « Les origines du répertoire d'action collective contemporaine en France et en Grande-Bretagne », *Vingtième Siècle. Revue d'histoire*, vol. 4, n° 1, 1984, p. 95.
[3] See in this issue: Laure Wolmark, "'We don't do mental health': a review of *Médecins Sans Frontières*' first '*psy*' mission", pp. 8–19.

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At the turn of the millennium, these systems are being restructured throughout the entire humanitarian sector in an endless process,[4] in line with the market dogma that is also asserting itself in the emerging framework of "global health", a new system of governing public health in line with neo-liberal globalisation.[5] MHPSS has now become part of this framework, and we are witnessing the emergence of "global mental health":[6] mental health is becoming a global public health issue with redefined challenges, a new research agenda and new tools. This vision of mental health underscores the importance of equity. To achieve equity, the social problems that limit the effectiveness of any therapeutic approach need to be addressed. To this end, the World Health Organization (WHO) Commission on Social Determinants of Health[7] is trying to reintroduce factors from the socio-political context. Despite this effort, this approach will not transform the scope of MHPSS action in any real sense, besides prompting the emergence of integrated programmes. Over the years, MHPSS programmes have often been severely constrained by the availability of funding that, in addition to being openly recognised as insufficient, sets binding guidelines whilst calling for innovation. It is according to this double mandate that, in order to be considered innovative, psychosocial actions must return to the fundamentals of the aid relationship, such as active listening, empathy and unconditional positive regard.[8]

Today, with global health affected by the pandemic and the climate crisis, we find ourselves on the threshold of a new critical juncture where the need for innovation is stimulating the return of debate. It is clear, however, that there is not always the necessary space for debate in the day-to-day running of non-governmental organisations (NGOs). Admittedly, the WHO's World Mental Health Report[9] echoes this concern by referring to the billion people who live with a mental health disorder, the shortcomings in State policies[10] and delays to Sustainable Development Goal (SDG) 3.4 target on mental health. All these findings call the usual practices of MHPSS into question. This report itself is not short of ambiguities: at the same time that it codifies global mental health discourse, it also suggests transforming it by going beyond the biomedical definition of mental health.

This hegemonic vision of well-being coexists with other ways of interpreting health and well-being. One example of this is the diagnosis and treatment of post-traumatic stress disorder (PTSD), which offers a perspective on psychotrauma[11] and opens up a range of treatment options. On the one hand, there is a body of knowledge which mobilises the

[4] Perrine Laissus-Benoist, "The endless restructuring of the humanitarian sector: an inappropriate search for performance?", *Humanitarian Alternatives*, no. 9, 2018, pp. 52–62.
[5] Jean-Paul Gaudillière, « 2. De la santé publique internationale à la santé globale. L'OMS, la Banque mondiale et le gouvernement des thérapies chimiques », *in* Dominique Pestré (dir.), *Le gouvernement des technosciences. Gouverner le progrès et ses dégâts depuis 1945*, La Découverte, 2014, p. 65–96.
[6] Vikram Patel, Harry Minas, Alex Cohen *et al., Global Mental Health: Principles and Practice*, Oxford University Press, 2013.
[7] World Health Organization, *Closing the gap in a generation: health equity through action on the social determinants of health – Final report of the commission*, 2008, https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1
[8] See the Friendship Bench in Zimbabwe: https://www.friendshipbenchzimbabwe.org
[9] World Health Organization, *World mental health report. Transforming mental health for all*, June 2022, https://www.who.int/publications/i/item/9789240049338
[10] See also the latest Atlas report: World Health Organization, *Mental health ATLAS 2020*, 2021, https://www.who.int/publications/i/item/9789240036703
[11] Maximilien Zimmermann, « Repenser les conséquences et la prise en charge psychologiques des traumatismes dans des contextes fragiles », *Rhizome*, vol. 3-4, n° 69-70, 2018, p. 27.

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biomedical model of suffering and which, in an attempt to professionalise the sector, has developed empirical tools and intervention methods (see the Mental Health Gap Action Programme-mhGAP).[12] These popular models are also designed from a public health perspective to address global mental health needs, but if this catalogue of tools allows mental health services to be integrated within community health services, it runs the risk of reducing responses to the implementation of therapeutic action algorithms[13] which place technical solutions rather than an authentic aid relationship at the heart of MHPSS.

On the other hand, we note the reference to practices which have their roots in the psychology of liberation, one of whose founders calls for our professional practices to be de-ideologised.[14] This movement seeks to denounce the use of certain concepts that, despite their alleged neutrality, convey an ideological system by referring to scientific data. By deconstructing the notion of trauma, for example, this movement instead acknowledges the impact of political violence on affected communities.[15] MHPSS action will therefore focus on their resilience by aiming for social justice, as has been the case with the psychologists actively engaged in supporting victims of torture at the hands of the Chilean dictatorship and, subsequently, in the truth and reconciliation processes.[16]

Whilst it does not resolve this tension (incidentally, that was not its objective), this issue of the review, thanks to the six preceding articles, makes it possible to include a diversity of voices and perspectives in a critical construction of the discourse on the change of knowledge and know-how within MHPSS.

The reality of global mental health in action

Take the case study presented by our colleagues from ALIMA and Trauma Aid France in Burkina Faso,[17] in which we can read about all the key elements of global mental health in a humanitarian crisis. Firstly, we see the dramatic observation that there is a growing need for mental healthcare which is hampered by the weakness – if not the absence – of adequate protection and psychological support services, despite the promises of national policies and action plans in this area. Such a gap between words and deeds would seem to confirm the barriers to introducing the systems described in the aforementioned WHO report: the lack of institutional and budgetary commitment. The experience of NGOs in the field bears witness to the consequences of such shortcomings, particularly with regard to the shortage of specialist staff – a major challenge for ensuring access to services. This

[12] World Health Organization, *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*, 2015, https://www.who.int/publications/i/item/9789241548922
[13] China Mills and Eva Hilberg, "'Built for expansion': the 'social life' of the WHO's mental health GAP Intervention Guide", *Sociology of Health & Illness*, vol. 41, no. 1, pp. 162–175.
[14] Ignacio Martin-Baró, « La desideologización como aporte de la psicología social al desarrollo de la democracia en Latinoamérica », *Boletín de la Asociación Venezolana de Psicología Social*, vol. VIII, no. 3, 1985.
[15] Pau Pérez Sales, *Actuaciones psicosociales en guerra y violencia política*, Ediciones Exilibris, 1999.
[16] *Idem*.
[17] See in this issue: Dodo Ilunga Diemu, Adeline Pupat, Victoire Hubert *et al.*, "Treating mental health in conflict zones in Burkina Faso with Traumatic Stress Relief (TSR)", pp. 20–33.

results in a "treatment deficit". Nevertheless, some criticise this observation since this problem emerges only if we accept the assumption that treatment is the solution.[18] In order to offer MHPSS treatment as part of basic services, the strategy that emerges from this observation is that of "task shifting"[19] which allows non-specialised staff to be involved in MHPSS. Such a strategy is criticised both for the lack of conclusive research on its benefits and its unexpected consequences such as the institutionalisation of the solidarity of volunteers who are trained in MHPSS.[20] Yet it remains the preferred option of MHPSS teams. This can only be achieved with short training courses (and regular supervision, which is not always possible) on techniques that vary in their simplicity and effectiveness.[21]

Despite years of effort in this direction, the global mental health agenda remains ongoing, and the needs are increasingly urgent with every day that passes. Are these strategies and tools still relevant in a sector that has changed? Should we invest more limited resources in following up on their hypothetical promises?

Elements for a review

It is with these questions in mind that the debate on coloniality[22] comes knocking at the door. This concept reveals the deep-rooted dynamics that drove the colonial project and are reproduced in other forms today. Several contributions in this issue highlight some of the key elements. A journey into the radical precariousness of the homeless in France,[23] marked by the crucial demands of "bare life",[24] shatters the separation between the "here" and the "elsewhere" where humanitarian action is played out, "in the field", where "expatriates" risk their lives. They are the ones who, in MHPSS programmes, have the power to select problems and develop solutions. Given their values, however, they also bring along their own cognitive biases and social norms at the risk, for example, of turning a blind eye to certain groups or, in contrast, stereotyping others. In the Congolese context,[25] where NGOs play a leading role in ensuring the availability of mental health services, the framework and organisation of these services are subject to the standards and procedures of the humanitarian system. In this case, as Bénédiction Kimathe and Camille Maubert tell us, this system results in the exclusion of men who are victims or perpetrators of violence from mental healthcare.

[18] China Mills, *Decolonizing Global Mental Health. The psychiatrization of the majority world*, Routledge, 2014.
[19] Nagendra Prasad Luitel, Mark J.D. Jordans, Brandon A. Kohrt *et al.*, "Treatment gap and barriers for mental health care: a cross-sectional community survey in Nepal", *PLoS ONE*, vol. 12, no. 8, 2017.
[20] Sudarshan R. Kottai and Shubha Ranganathan, "Task-shifting in community mental health in Kerala: tensions and ruptures", *Medical Anthropology*, vol. 39, no. 6, 2020, pp. 538–552.
[21] Ignacio Martin-Baró, «La desideologización…», *art. cit.*
[22] See in this issue: Guillaume Pégon, Christian Laval and Marie Viviane Goupougouni Leni, "Coloniality and intersectionality in mental health: a rallying call", pp. 34–47.
[23] Thibaut Besozzi and Charles-Henry Lelimouzin, "The mental health of the homeless viewed through the prism of the temporalities of survival and institutions", pp. 74–83.
[24] Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, Stanford University Press, 1998.
[25] See in this issue: Bénédiction Kimathe and Camille Maubert, "Areas of exclusion, masculinity and mental health in the Democratic Republic of the Congo", pp. 48–59.

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The excursus in France also shows us the discrepancy between the "lived temporality" and the "institutional temporality" of social services mechanisms, which is mirrored in the misalignment of humanitarian projects. The concept of the humanitarian – development – peace nexus only partially resolves this asynchronous, misaligned and ephemeral solidarity. MHPSS projects are all too often designed for the short term: a few sessions in which to "intercept" people who are suffering and overwhelmed by the multiple priorities of survival. The possibilities of meeting the other person, building a bond of trust, support, recovery and inclusion are out of reach. Here, there is a discrepancy between the lived experience of a community in its socio-cultural context and the universalist notions and categories of the MHPSS discourse.

This discourse is developed and legitimised in international task groups and mechanisms (such as the Inter-Agency Standing Committee), in which networks of experts, mainly based in the "minority world", participate. Here, MHPSS is built with a great deal of standardised content, guidelines and indicators. These indicators and their interpretative framework have been the subject of numerous attempts to standardise them in order to address evaluation and monitoring needs from a cost-benefit angle, with a narrative of success stories and the emphasis on effectiveness and performance. These technical measuring devices reinforce the aetiological and nosographic system in force.[26] All this is clearly in line with the neo-liberal ideological framework and the way globalisation works, which is one of the causes of the structural inequality and violence that are largely responsible for generating humanitarian crises. In the global mental-health discourse, we navigate between the fatality of "philanthrocapitalism" [27] and calls to deconstruct its ideology in order to move towards greater social justice.

An emerging transformation

Among the priority issues that drive global mental health networks today,[28] we find the search for "optimal" interventions (those that are effective, efficient, cost-effective, safe) and monitoring and evaluation methods. Perhaps they will help optimise the current intervention model, but they will not necessarily prepare the world of tomorrow. Yet this world is emerging right now given the increasing number of disasters caused by the climate crisis (consider the situation in Pakistan)[29] or the climate-related health crises which have a slow but irreversible onset (consider the situation in Afghanistan).[30]

[26] See in this issue: Florence Chatot and Mahamat Mbarkoutou, "Standardisaton challenged by local dynamics: the example of mental health programmes in the Chad Basin", pp. 60–73.
[27] Colin D. Butler, "Philanthrocapitalism: promoting global health but failing planetary health", *Challenges*, vol. 10, no. 24, March 2019.
[28] Phuong Thao Le and Wietse Tol, *Mental health and psychosocial support in humanitarian crises: setting consensus-based research priorities for 2021-2030 (MHPSS-SET 2)*, Elrha, 2023, https://www.elrha.org/researchdatabase/mental-health-and-psychosocial-support-in-humanitarian-crises-setting-consensus-based-research-priorities-for-2021-2030
[29] OCHA, *Business Brief: Pakistan Floods Response Plan – Humanitarian Overview and Call to Action*, 12 September 2022.
[30] Waniyah Masood, Sakina Aquil, Hamid Ullah *et al.*, "Impact of climate change on health in Afghanistan amidst a humanitarian crisis", *The Journal of Climate Change and Health*, vol. 6, article no. 100139, May 2022, pp. 2667–2782.

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In order to address these new challenges, the WHO recently published a preliminary paper[31] on the mental health aspects to be considered in a "warmer" world yet without providing any operational guidelines. In any case, the MHPSS sector has acquired significant expertise during humanitarian crises that can help structure the MHPSS response before and after crises caused by climate change. The experience of accompanying complex grief can be used to deal with "ecological grief",[32] even if we are currently powerless in terms of socially codified forms for coping with and marking it.[33] Knowing how to manage distress will allow us to deal with the mental fatigue and moral injuries of climate activists, and experience of MHPSS in conflict management will undoubtedly be useful in new social conflicts caused by the increase in forced migration, the scarcity of vital resources, and growing inequalities.

Yet global mental health in the Anthropocene Epoch requires more than simply scaling up its current practices. Mental health professionals have a crucial role to play and a mission that goes well beyond treatment.[34] It is only by embedding mental health in the paradigm of planetary health[35] that we will find a narrative capable of synthesising critical elements, initiating real change and restoring hope. The starting point is the realisation that we are living in a new geological epoch, the famous Anthropocene, but also in the Capitalocene[36] – a model of society which, despite its promises, weakens the very conditions of life on Earth by endangering human health, not to mention the other ecosystems to which we also belong.

Overwhelming the biosphere's life support systems presents us with a collective existential challenge where anxiety becomes an adaptive response, but treatments focused on reducing the symptoms cannot be fully effective when it is the lack of meaning that contributes to increasing ontological insecurity. We urgently need an epistemological revolution capable of projecting a relational and circular worldview. We must reconfigure our relationship with otherness, i.e. our own limits, until we can offer a new definition of humanity[37] that will result in a rethink of humanitarian aid practices.

The contributions in this issue attest to this: mental health in the Anthropocene Epoch will have to reorient itself towards community, collective and committed work in order to bring about behavioural and social change for planetary well-being.[38]

Translated from the French by Derek Scoins

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[31] World Health Organization, *Mental Health and Climate Change. Policy brief*, June 2022, https://www.who.int/publications/i/item/9789240045125

[32] Ashlee Cunsolo and Neville Ellis, "Ecological grief as a mental health response to climate change-related loss", *Nature Climate Change*, vol. 8, no. 4, April 2018, pp. 275–281.

[33] Britt Wray, *Generation Dread. Finding Purpose in an Age of Climate Crisis*, Knopf Canada, 2022.

[34] Ching Li, Emma L. Lawrance, Gareth Morgan *et al.*, "The role of mental health professionals in the climate crisis: an urgent call to action", *International Review of Psychiatry*, vol. 34, no. 5, 2022, pp. 563–570.

[35] Samuel Myers and Howard Frumkin, Planetary Health: *Protecting Nature to Protect Ourselves*, Island Press, 2020.

[36] Jason W. Moore, *Anthropocene or Capitalocene? Nature, History, and the Crisis of Capitalism*, PM Press/Kairos, 2016, https://jasonwmoore.com/wp-content/uploads/2017/08/Moore-ed-Anthropocene-or-Capitalocene-Introduction-and-TOC-2016.pdf

[37] Miriam Iris Ticktin, "From the human to the planetary. Speculative futures of care", *Medicine Antrhopology Theory*, vol. 6, no. 3, 2019, pp. 133–160, http://www.medanthrotheory.org/article/view/4960/6983

[38] JYU.Wisdom community, "Planetary well-being", *Humanities and social sciences communications*, vol. 8, 2021, p. 258.

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Biography

Davide Ziveri • A specialist in planetary health at the NGO Humanity & Inclusion (Handicap International), in charge of the health prevention methodology called Communication pour le changement social et comportemental (Social and Behavioural Change Communication). Davide Ziveri obtained his PhD in Social Psychology at the Universidad Complutense in Madrid (Spain) where he discovered Latin American psychology. Committed to non-violence, Davide has over twenty years' experience in mental health and psychosocial support (MHPSS) with national and international teams on humanitarian aid projects (in Chile, Burundi, the Occupied Palestinian Territories and Syria for example). Active in several international health networks, he advocates for interdisciplinary collaboration in order to work together on the social and environmental determinants of health. He recently completed a postgraduate qualification in Global Health Policy at the London School of Hygiene and Tropical Medicine.